SECTION 11
FREQUENTLY ASKED QUESTIONS

INPATIENT HOSPITAL

How does a provider submit an inpatient claim that requires a two-page claim for all the services?
If at all possible, the provider should list all the services on a single claim form. If this is not possible, the provider may bill the services on two claim forms. In field 84 on the first page of the claim, put "page 1 of 2". In field 84 of the second page, put "page 2 of 2". Staple the claims together prior to submission.

Does a provider have to submit a claim to Medicare for a patient who has exhausted his/her Medicare inpatient benefits and get a denial from Medicare before filing a claim to Medicaid?
Yes. Medicaid requires that a claim be filed to Medicare first before filing a claim to Medicaid. Once the denial has been received, a paper claim can be filed to Medicaid and a copy of the Medicare denial attached to it. The range of dates on the claim to be filed to Medicaid must fall within the range of dates on the claim filed to Medicare. The denial code description should be visible on the Medicare denial or on an attached sheet.

Do **not** put a Part A Medicare crossover sticker on the Medicaid claim. If a sticker is put on the claim, Infocrossing will return it to the provider.

Are hospitals required to keep paper copies of attachments related to physicians' inpatient services, e.g. Second Surgical Opinion Form, Sterilization Consent form, etc.?
Yes. The hospital must maintain a paper copy of these forms in the patient's permanent file.

Is the inpatient hospital per diem rate based on the date of admission or the date of service when there is a rate change?
The per diem rate is based on the date of admission.

A hospital receives certification for a patient admission and admits the patient. Later in the admission day, the patient has to be transferred to another facility which also needs certification. How is this processed and how would the services be billed?
The Medicaid *Hospital Provider Manual*, Section 13.30.B - DAY OF DISCHARGE, DEATH, OR TRANSFER states: "Missouri Medicaid reimburses a facility for the day of admission. Medicaid does not cover the day of discharge, death or transfer **unless it also is the day of admission and then it is reimbursable**. The costs for the day of discharge, death or transfer cannot be billed to the recipient."

In the example above, both facilities must obtain certification from Health Care Excel. Whichever facility submits a properly completed claim to Medicaid first should receive reimbursement. The facility that submits a claim to Medicaid second will have its claim denied as a duplicate unless a completed *Certificate of Medical Necessity* is submitted with the claim to justify the care on the same date of service. It is advisable, however, for both facilities to submit a completed *Certificate of Medical Necessity* with their claims to avoid a duplicate service denial.

A hospital wants a pre-certification for a pregnant woman for a medical condition unrelated to the pregnancy, e.g. mental health services. Should a pregnancy diagnosis code be reported?
HCE does not review most pre-certifications if the admitting or primary diagnosis code is related to pregnancy. Therefore, a diagnosis code relating to pregnancy should **not** be used as the admitting/primary diagnosis code. If the hospital stay is not related to pregnancy, it must be clear that the pregnancy is incidental to the admitting/primary diagnosis.

Are there special documentation requirements for billing for inpatient missed abortions/miscarriage services?
Missouri Medicaid does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-92 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with one of the following ICD-9 surgical codes: 69.02, 69.93 or 73.1.

ICD-9 surgical codes 69.01, 69.51, 69.93, 69.99, 74.91, 75.99, and 96.49 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.

OUTPATIENT HOSPITAL

Is a pre-certification required from Health Care Excel for outpatient services and/or surgical procedures?
No, a pre-certification is not required for outpatient services and/or surgeries.

If a hospital has an outpatient claim that requires the submission of a second page for services provided on the same date, should two separate claims be filed

or can a two-page claim be submitted with the total appearing on the second page?
In this instance, the provider should submit two separate claims and total each individual page.

When billing for an outpatient facility charge, should a CPT/HCPCS code be entered in addition to the outpatient facility revenue code?
No. Enter only the appropriate outpatient facility revenue code. Do **not** list a CPT or HCPCS code along with the facility revenue code.

Can a provider bill for two emergency room visits on the same day for the same patient?
If the second ER visit is essentially for the same reason as the first, the hospital cannot bill for it. If the second visit is for a different reason, the hospital can bill for the visit. The two visits must be billed on the same paper claim and the ER notes for each visit attached to it.

If the patient has two ER visits on the same day at two different hospitals, whichever hospital submits a claim first will be paid. The provider that bills second will have its claim denied and will have to refile a paper claim with the ER notes attached to it.

How are emergency room services billed that continue from the initial day into the following day?
If the hospital intends to submit a claim and list condition code AJ in field 24 (to exempt the patient from being responsible for the cost sharing amount), the services will have to be billed on two separate claims, one for services on the initial day and the one for the services on the following day. The AJ condition code should be listed only on the claim for first day's services.

Can a hospital bill for multiple dates of service on the same claim for either emergency room services or therapy services and use the AJ condition code to exempt the patient from the $2.00 cost sharing amount for each date of service reported on the claim?
No. Only one date of service can be reported on an outpatient hospital claim on which the AJ condition code is reported. The AJ condition code is used on the outpatient hospital claim to exempt the patient from the $2.00 cost sharing for emergency room services or outpatient therapy services (physical therapy, chemotherapy, radiation therapy, psychology/counseling and renal dialysis).

A Medicaid patient presents to the hospital emergency department for non-emergent care. Eligibility is checked and it is determined the patient is administratively locked-in to a provider. The ER department tries to contact the designated lock-in provider who either is not available or will not authorize the services through the PI-118 lock-in form. Since the ER department cannot get a referral from the lock-in provider, can these services be billed to the patient or does the hospital have to write them off?

The patient can be billed for the care. Patients who have been administratively locked-in to a designated provider know this and know who their lock-in provider is. Further, they know that if they try to obtain non-emergent services from another provider, the patient can be held responsible for the costs of the service if the treating provider is unable to obtain a referral from the lock-in provider.

How does a hospital bill for an injection for which there is no J-code?
If there is no appropriate J-code for an injection, the hospital can bill one of the following codes.

J-3490 – unclassified drug
J-7599 – immunosuppressive, not otherwise classified
J-8499 – prescription drug, oral, non-chemotherapeutic, NOS
J-8999 – oral prescription, chemotherapeutic, NOS

The injection code will have to be filed on a paper claim and an invoice **must** be attached which shows the name, the national drug code and the cost for the drug.

Can I bill for a non-payable injection under medical supplies?
No. An injection with a J-code that is not payable under Missouri Medicaid **cannot** be billed under revenue code 270 (medical supplies).

Are hospital's required to keep paper copies of attachments used for physicians' outpatient services, e.g. Second Surgical Opinion Form, Sterilization Consent form, etc.?
Yes. The hospital must maintain a copy of these forms in the patient's permanent file.

Can HCPCS "Q" codes be used to bill for Medicaid services?
HCPCS "Q" codes are national codes given by the Center for Medicare Services (CMS) on a temporary basis. In general, "Q" codes are not to be used to bill for Medicaid services and are considered non-covered.

Does Medicaid have allowable quantities that can be billed for outpatient services?
Yes. Each procedure code has an allowable quantity that can be billed to Medicaid without additional documentation. A provider can access the Medicaid fee schedules, which include allowable quantities, through the Division of Medical Services website, www.dss.mo.gov/dms.

How is a claim billed when more than the allowable quantity of a procedure was performed?
A provider cannot bill for more than the Medicaid allowable quantity on a single line on the claim. The additional quantities have to be billed on subsequent lines and the hospital's notes sent with the claim for manual review and processing. Example - the Medicaid allowable for a procedure is two but the hospital wants to bill for 5. The hospital would bill one line with the procedure code and a quantity of two, a second line

with the procedure code and a quantity of two, and a third line with the procedure code and a quantity of 1, and the hospital notes submitted with the claim.

What is the proper way to bill for a comprehensive metabolic panel, procedure code 80053?
If only CPT code 80053 was performed, bill the code without any modifiers. Providers should be aware that 80053 might be included in CPT code 80050 (general health panel) if certain other lab services are being billed for the same date of service.

CPT code 80050 includes 80053 in addition to:

> Blood count, complete (CBC), automated and automated differential WBC count (80025 or 85027 and 85004) or,
>
> Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)
>
> Thyroid stimulating hormone (TSH) (84443)

Since procedure codes 93797 and 93798 are no longer covered, what is the correct way to bill for outpatient cardiac rehabilitation services?
For dates of service October 16, 2003 and after, providers should bill using the appropriate revenue code, 0943 - cardiac rehabilitation. Do **not** list a CPT procedure code with this revenue code. For dates of service prior to October 16, 2003, providers should use CPT codes 93797 and 93798.

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The above information is required also when submitting a claim with one of the following CPT codes: 59200, 59812, 59821, or 59830.

CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, and 59866 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.